Providers: ☐ Heidi Gallo, ARNP ☐ Cyndi Byers, ARNP

908 Dupont Road, Ste 100 Louisville, KY 40207

Office 502 883-3147 FAX 502 882-0909

Today's Date: [Date]	PCP:

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: _____

SEX: ☐ M ☐ F MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

STREET ADDRESS: _____

CITY: _____ STATE_____ ZIP_____

SOCIAL SECURITY#: _____

MAILING ADDRESS (IF DIFFERENT FROM STREET) _____

CITY: _____ STATE_____ ZIP_____

EMAIL ADDRESS: _____@ _____.____

PHONE: HOME: _____ CELL: _____

WORK_____

PRIMARY LANGUAGE_____

RACE: ☐ BLACK/AFRICAN AMERICAN ☐ WHITE/CAUCASIAN ☐ HISPANIC/LATINO ☐ NATIVE HAWAIIAN

☐ AM INDIAN/ALASKA NAT ☐ ASIAN/E INDIAN ☐ UNAVAILABLE/UNKNOWN MAY CHOOSE MULTIPLE RACES

☐ DECLINED TO PROVIDE ETHNICITY

PRIMARY CARE PHYSICIAN: _____

DME COMPANY (CPAP SUPPLIES / OXYGEN) : _____

PHARMACY / DRUG STORE: _____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Name of Insurance _____

Policy Number_____Group Number _____

Co Pay Amount _____Effective Date_____

SUBSCRIBER INFORMATION (Person who carries the insurance) [ ] Check here if same as the patient

Name:_____DOB_____

Mailing Address: _____ City: _____

State_____ Zip_____

Social Security#: _____ Relationship to Patient:_____

Name of Secondary Insurance: _____ Policy Number_____

Group Number _____Co Pay Amount $_____

Effective Date_____

SUBSCRIBER INFORMATION (Person who carries the insurance) [ ] Check here if same as the patient

Name:_____DOB_____

Mailing Address: _____ City: _____

State_____ Zip_____

Social Security#: _____ Relationship to Patient: _____

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
[Friend or relative name]		[Phone]	[Phone]
Allergies Yes☐ NO☐			

Do you Smoke cigarettes, Chew Tobacco	Yes ☐	NO ☐	
When did you quit smoking – Date:			

** As a courtesy to our office as well as to those patients who are waiting to schedule with the physician, please give us at least a 48 hour notice. If you do not cancel or reschedule your appointment with at least a **48** hour notice, we may assess a $50.00 "no-show" service charge to your account**. This "no-show charge" is not reimbursable by your insurance company. You will be billed directly.**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Access Care Plus. I understand that I am financially responsible for any balance. I also authorize Access Care Plus or insurance company to release any information required to process my claims.

Patient/Guardian signature _____ Date _____

FINANCIAL INFORMATION

I understand the "no-show" policy of Access Care Plus and agree to provide a credit card number, which may be charged $50.00 for any no-show of a scheduled appointment. I understand that I must cancel or reschedule any appointment at least 48 hours in advance.

This information is to provide clarification for patients of Access Care Plus regarding matters of insurance, co-pay, deductibles and co-insurance amounts due at the time of service. Co-Pays-You will be required to pay your co-payment upon arrival for your appointment Deductibles and Co-Insurance-You will be asked at check in or check out for any deductible or co-insurance that may be applicable to your office visit Previous Balances-You will be expected to provide payment for previous balances or balances sent to collections prior to your office visit.

If you are unable to pay your balance in full, you may be asked to set up a payment plan. Please call 502-883-3147. speak with the practice manager.

While, filing insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. Your insurance is a contract between you, your employer and the insurance company, we are not party to that contract. Before your visit, contact your insurance company to verify that we are participants in your plan, and that the services you intend to receive are covered. In order for us to file a claim, you must present a CURRENT copy of your insurance at each visit and communicate any changes in your personal information. PLEASE SIGN THE ACKNOWLEDGMENT BELOW I acknowledge that the above information is true and accurate demographic and insurance information for the patient listed on this registration form. I also acknowledge that by signing this form, I authorize payment of medical benefits to the undersigned physician or supplier for services described.

Patient Signature_____ Date:_____

HIPPA INFORMATION

HIPAA RELEASE OF INFORMATION (Please choose an option below)

HIPAA DELEGATES

[ ] OPTION 1: THESE ELECTIONS WILL BE IN EFFECT FOR Access Care Plus I authorize the person (s) listed below to receive all health information about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided at Access Care Plus

Name:_____Relationship:_____

Phone:_____

Name:_____Relationship:_____

Phone:_____